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HEALTH POLICY INITIATIVE

Analysis of Policy, Legal, and Regulatory Frameworks for Task Shifting in Tanzania

AUGUST 2013

Introduction

Human resources for health (HRH) are both a crucial determinant of health and development and vital for the successful scale-up of HIV/AIDS and reproductive and child health services (Zinnen et al., 2012). However, many sub-Saharan countries face a shortage in HRH. This is no less true in Tanzania, where a critical deficit in human resources—specifically, a lack of available skilled personnel, insufficient staff retention plans, inadequate staff deployment, hiring delays, and limited capacity building and funding—threatens the health sector. To remedy this situation in the long run, several interventions will need to be implemented. Yet implementation of these interventions will require significant financial resources and time. In the short term, several stopgap measures are being advocated, including task shifting.

Task shifting (also called task sharing)—in which less specialised skills and tasks are transferred to less specialised and less trained cadres of health workers—is being adopted by various countries as part of their solution to the HRH shortage. In fact, task shifting is practised extensively in rich and poor countries alike, and the World Health Organization (WHO) has endorsed task shifting as a measure for dealing with HRH shortages and sustaining high-quality service delivery in the health sector (NIRM, 2013). Furthermore, task shifting has been practised informally in Tanzania for some time. Yet despite its ongoing practice and evidence of widespread in-country support for and international consensus around task shifting, it has not yet been adopted formally to the extent endorsed by WHO.

To address this challenge, Tanzania's National Task Shifting Task Force asked the Health Policy Initiative in Tanzania (HPI/Tanzania) to assess relevant policy, legal, and regulatory frameworks, and determine whether they would support or hinder the formal adoption of task shifting in Tanzania. To do so, HPI/Tanzania undertook a desk review of relevant policies, laws, regulations, and guidelines, as well as both individual interviews and focus group discussions among key HRH stakeholders. Stakeholders included individuals with medical and programmatic backgrounds from various government ministries, Tanzanian health professional associations, and relevant international organisations.

Findings

Although various policy documents recognise Tanzania's critical human resources shortage and the resulting negative impact on service delivery, almost none—with the exception of the *HIV and AIDS Strategic Plan II (2008–2012)*—sufficiently address task shifting. In fact, most of the existing legal and regulatory frameworks appear to restrict the practice. That said, task shifting has been practiced informally in Tanzania for years, and most stakeholders see task shifting as inevitable due to the heavy workloads of health workers resulting from the HIV epidemic. Feedback during the focus group discussions and key informant interviews revealed unanimous support for the adoption, formalisation, and regulation of task shifting in Tanzania, albeit with some conditions. Key stakeholders identified the following as necessary components of a task shifting strategy:

- Task shifting needs to be well regulated, with a view to ensuring that standards and quality of care are not compromised in its implementation. This extends to the registration and licensing of all healthcare professionals; currently, some cadres of health professionals are not subject to the same regulation as others, making accountability difficult.
- The adoption of task shifting should be gradual and evaluated in stages, and there should be consensus building among key stakeholders on the mode of adoption.
- Concerns, especially among senior medical personnel, that task shifting may compromise the quality of healthcare in Tanzania need to be addressed.

- Given the unfamiliarity of task shifting among many health service providers and managers, there is a need for advocacy and information dissemination throughout the health system. In addition, as task shifting demands the investment of resources for extra incentives or salaries to encourage individuals to take on extra tasks, advocacy targeted at decisionmakers will be necessary to help overcome their potential reluctance to commit extra resources to these incentives.

The legal and regulatory frameworks for task shifting—including the regulations and laws governing medical professionals and the extent to which they support task shifting—need to be better understood and there needs to be a national policy to guide and streamline the practice of task shifting in Tanzania.

Task Shifting Under the Existing Policy, Legal, and Regulatory Frameworks

With these conditions in mind, HPI found that there are various provisions in the current legal and regulatory frameworks that could be exploited to support some form of task shifting in Tanzania and help address the HRH shortage, specifically:

- The regulatory councils for medical practitioners, nurses, and pharmacists are authorised by law to identify conditions and criteria under which health personnel can qualify to perform certain duties. These powers could be harnessed to facilitate task shifting by approving curricula that offer short-term but specialised training and also by approving the qualifications of practitioners who undergo this training.
- There are tasks and procedures that easily could be shifted from one healthcare professional to another without breaking the law. Section 14 of the Medical Practitioners Act grants the Minister of Health and Social Welfare the power to allow nurses to undertake medical tasks and procedures normally conducted by more specialised medical practitioners. To date, the minister has seldom exercised this power, and few people are aware of it. However, this power could be utilised to roll out task shifting.
- There are key personnel within the health sector, such as clinical officers and assistant clinical officers, who are not regulated by any law or under supervision of any of the regulatory councils. Despite this lack of regulation, these clinical officers and assistant clinical officers constitute a large percentage of the health sector's service providers, and thus can play a key role in the adoption of task shifting. However, for task shifting to succeed, these cadres need to be regulated.

Findings from Related Studies

Over the years, the Ministry of Health and Social Welfare (MOHSW) has sought to implement a number of interventions to address the HRH shortage in Tanzania—most aimed at expanding the country's health workforce and facilities. To date, these efforts have not been able to keep pace with increasing health service demands, and recent studies have shown that there is instead a need to focus on improving the quality and management of existing facilities and staff rather than only increasing their number (Manzi et al., 2012; Zinnen et al., 2012). This could be achieved through a comprehensive plan for task shifting. Preliminary findings from a recent analysis (still being finalised) by the National Institute for Medical Research (NIMR) found that task shifting—particularly as it relates to HIV/AIDS and reproductive and child health service delivery—is practiced widely in Tanzania, albeit informally. While task shifting practices exist at all levels of health facilities regardless of their ownership and geographical location, it occurs to a greater extent at rural facilities, with the majority of work falling to nurses and medical attendants. The trend towards task shifting is due primarily to a reaction to the overall HRH shortage, but also to high levels of absenteeism (e.g., senior health workers delegating tasks to junior staff so the former can attend trainings, workshops, and seminars) and, in some cases, out of a sense of teamwork.

Box 1. Operational challenges related to task shifting

- Increased workload without extra payment
- A lack of equipment to perform the tasks assigned
- Low knowledge/skills to perform the tasks shifted; training on the shifted tasks often is nonexistent, haphazard, and/or inconsistent in duration
- A lack of supportive mentorship and supervision
- Low confidence among health workers in performing other workers' duties
- Negative attitudes; specifically, complaints from patients, including some patients who refuse "to be attended by health workers of the lower cadre or nonprofessionals, as they believe that they will not get appropriate treatment or poor quality care"
- An absence of guidelines and policies

Source: NIMR 2013, preliminary findings

A 2012 study examining HRH in Tanzania observed that, in addition to the overall shortage of front-line health workers, absenteeism and a low productivity among staff (estimated at 57 percent of those studied) exacerbated healthcare inefficiency (Manzi et al.,

2012). The authors of the study argue that because lower cadres of health workers often are insufficiently trained to take on additional tasks, and task shifting generally is seen as an illegal practice (particularly when it involves prescribing medications), patients often seek out providers they perceive to be of better quality, leaving lower cadres of health workers in certain areas with few patients to treat (Manzi et al., 2012). Thus, formalising task shifting and adequately training workers to take on additional clinical functions would improve the efficiency of the current healthcare system. Another study found that low motivation among staff—including low productivity—was the second highest contributor to low health service quality after staff shortages and was fuelled primarily by poor working conditions (Zinnen et al., 2012).

While preliminary findings from the NIMR analysis reported a number of operational challenges related to task shifting (see Box 1 on page 2), most of these challenges could be overcome by formalising task shifting and putting nationally approved policies and guidelines in place to govern and support it. In fact, the NIMR study suggests that the most pressing challenge posed is the informal nature of current task shifting practice and the lack of a legal mandate. This finding is supported by other recent studies which conclude that (1) productivity gains can be achieved through enhancing efficiency rather than increasing resources; and (2) improving health workers' environment—most notably training, management, and supervision—is the primary factor that should be tackled to increase health worker motivation and productivity and client confidence in health services (Manzi et al., 2012; Zinnen et al., 2012).

Summary and Recommendations

The HPI assessment, NIMR analysis, and other recent studies on HRH support task shifting as a viable option for addressing the current HRH shortage in Tanzania and its impact on service delivery. Given the prevalent nature of the practice, what is needed most is the creation of enabling policy, legal, and regulatory frameworks and nationally approved guidelines that will formalise the practice, improve working conditions, and increase productivity of health workers and patient confidence in the health system.

To address the current HRH crisis and improve service delivery in Tanzania, HPI recommends that Tanzania formalise the practice of task shifting, beginning with the steps outlined in Table 1.

In addition, the MOHSW should consider the recommendations outlined in the NIMR analysis and other recent studies on HRH calling for adequate remuneration for health workers, including nonfinancial incentives (e.g., positive working and living environments, supportive management, training and recognition, career development), as well as improved service integration and health services management (Manzi et al., 2012; Zinnen et al., 2012; NIMR, 2013; Makota et al., 2010).

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Table 1. Recommendations to the MOHSW to Advance Task Shifting in Tanzania

1.	Review, ratify, and adopt the WHO guidelines on task shifting to suit Tanzania, and utilise them to guide the process of formalising task shifting nationally.
2.	Convene a stakeholders meeting, chaired by the Chief Medical Officer, to review the following: ○ WHO guidelines on task shifting and the extent of their applicability in Tanzania; ○ 2008 National Stakeholders Report on Task Shifting organised by the MOHSW; following this, authorities should make use of the relevant recommendations; and ○ Evidence and best practices for ongoing task shifting activities in Tanzania, followed by developing strategies aimed at addressing the current HRH crisis by embracing task shifting as one of the key strategies.

3. Organise a joint meeting with professional councils and associations specifically on:
   - The procedure for review of the establishment of a relevant law providing the legal framework through which the practice of task shifting between and among all professions/disciplines will be regulated; and
   - Formation of a central technical team to coordinate the process of task shifting adoption/adaptation, practice, and regulation.

4. Establish a multidisciplinary regulatory body for health sector practitioners under the chairmanship of the Chief Medical Officer, with representation from the various regulatory councils, which can meet regularly to oversee cross-cutting issues touching on health practitioners, including such task shifting-related issues as the following:
   - Standardised training programmes/curricula and certification for all cadres to be involved in task shifting;
   - Establishment of a system of registration, licensure, and credentialing of all staff categories in the health sector, including clinical officers and assistant clinical officers, to make them both accountable and easily regulated; and
   - Deciding on the scope, type, and modality of task shifting needed; for example, beginning on a small scale with fewer cadres, and then expanding on an incremental basis using either horizontal or vertical task shifting, or both.

5. Explore and establish a practical and affordable remuneration system for the practice of task shifting.

6. Utilise the existing opportunities presented by the flexible legal and regulatory frameworks to put in place quick-win strategies with a view to scaling up health services rapidly through task shifting. This can be done collaboratively with stakeholders by enacting regulations and measures that can foster task shifting within the current legislative framework.

7. Utilise effectively the existing powers given to the Minister of Health and Social Welfare and various regulatory bodies under the current laws, and use them to formalise task shifting in Tanzania.

8. Amend the Medical Practitioners and Dentists Act, with a view to incorporating the cadres of clinical officers and assistant clinical officers and regulating them. Currently, this cadre is not regulated by any regulatory body, although it is now and will continue to be a key cadre when formal task shifting is launched.

9. Advocate for increased awareness and dissemination of the existing research/studies; relevant workshop recommendations; and policy, legal, and regulatory framework documents among key decisionmakers to foster their understanding and use of the findings, recommendations, and flexibilities in their day-to-day decisionmaking and practices.

10. Utilise the opportunities for health funding from external sources to lobby for government acceptance of task shifting—an approach recommended by key international institutions such as WHO and USAID through PEPFAR.

11. Implement the following activities to pave the way for a smooth adoption/adaptation of the practice of task shifting in the country:
    - A policy framework must be developed to guide the process.
    - Parliamentary acts for establishing various professional councils must be reviewed and updated to accommodate task shifting.
    - As an interim measure, a coordination technical team should be formed to serve as an umbrella central body of various professional councils and associations to involve them in a better way and spearhead the process.
    - A registration, licensure, and credentialing system should be established to cover all categories of health cadres so as to make them responsible, accountable, and easily regulated.

For more information, please contact

Health Policy Initiative, Task Order 5
Futures Group
One Thomas Circle, NW, Suite 200
Washington, DC 20005 USA
Tel: (202) 775-9680
Fax: (202) 775-9694

policyinfo@futuresgroup.com
http://www.healthpolicyinitiative.com

The Health Policy Initiative is implemented by the Futures Group. It is funded by USAID/Tanzania through the mission's Health and Population Office (for FP/RH activities) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (for HIV activities).